

# Butler County Dental Care Program

## Dedicated to special care dentistry

Butler County Board of Mental Retardation and Developmental Disabilities

Consumer \_\_\_\_\_

I give consent to the Butler County Dental Care Program to obtain and share, in a confidential manner, information relevant to my dental condition and or treatment, from my physician, specialist, dentist, family and Butler County Board of MRDD professionals.

I understand that the Dental Hygienist of the Butler County Dental Care Program may complete an oral screening to obtain information regarding my oral health.

Also, I understand that Dr. Ben Johnson may complete an oral examination to obtain information regarding my oral health. No radiographs (diagnostic x-rays) will be taken at the center.

The Butler County Dental Care Program charges no fee; it is a service of the Butler County Board of Mental Retardation and Developmental Disabilities.

If I request, the Butler County Dental Care Program will assist me in locating a dentist or an oral surgeon who can provide appropriate dental care. The program also provides links to oral hygiene aids, oral hygiene regimes, oral health education and in some limited cases transportation.

Dentists providing treatment shall not be considered agents of the Butler County Dental Care Program or Butler County Board of Mental Retardation and Developmental Disabilities.

I understand that it is not a function of this program to provide financial reimbursement to dentists for services or treatment.

I understand that the Butler County Dental Care Program may issue reports or statistics in summary fashion and specific names will not be a part of any document.

Signature of Consumer \_\_\_\_\_ Date \_\_\_\_\_

Signature of Consumer's  
Guardian \_\_\_\_\_ Date \_\_\_\_\_

Support/Habilitation Coordinator \_\_\_\_\_

Day Location \_\_\_\_\_

Referred by \_\_\_\_\_

**MEDICAL HISTORY**  
**BUTLER COUNTY DENTAL CARE PROGRAM**

**Full Name**

**Today's Date**

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**Address** \_\_\_\_\_ **City,** \_\_\_\_\_ **State,** \_\_\_\_\_ **Zip** \_\_\_\_\_

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**Home Phone** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_ **Medicaid Billing Number** \_\_\_\_\_

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**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Sex (Circle)** \_\_\_\_\_ **Marital Status (Circle)** \_\_\_\_\_

\_\_\_\_\_ FT. \_\_\_\_\_ IN. \_\_\_\_\_ LBS M F S M D W

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**Day Phone Number** \_\_\_\_\_ **Support Coordinator Name & Phone** \_\_\_\_\_

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**Physician Name & Phone** \_\_\_\_\_ **Pharmacy Name & Phone Number** \_\_\_\_\_

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**Guardian Name (if applicable)** \_\_\_\_\_ **Phone Number** \_\_\_\_\_ **Address** \_\_\_\_\_

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**CONDITIONS** Please mark Y (yes) or N (no) to all of the following:

- |  |                          |                          |                          |                                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |                          |      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| <table border="0"> <tr><td>Y</td><td>N</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Abnormal Bleeding</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Allergies</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Anemia</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Angina Pectoris</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Arthritis</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Artificial 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type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Sickle Cell Disease</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Sinus Problems</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Stroke</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>TBI</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Thyroid Problems</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Tuberculosis</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Ulcers</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Venereal Disease/STD</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><b>Yellow Jaundice</b></td></tr> </table> | Y | N | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hepatitis A</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hepatitis B</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>HIV+ AIDS</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>High Blood Pressure</b> | <input type="checkbox"/> | <input 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| Y  | N                        | <input type="checkbox"/> | <input type="checkbox"/> | <b>Abnormal Bleeding</b>         |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |                          |      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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Allergies</b>                 |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Anemia</b>                    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Angina Pectoris</b>           |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Arthritis</b>                 |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Artificial Bones/Joints</b>   |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Artificial Heart Valve</b>    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Asthma</b>                    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Blood Transfusion</b>         |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Cancer</b>                    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Cerebral Palsy</b>            |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Colitis</b>                   |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Congenital Heart Defect</b>   |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Diabetes</b>                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Difficulty Breathing</b>      |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Downs Syndrome</b>            |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Emphysema</b>                 |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Epilepsy</b>                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Fainting Spells</b>           |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Fever Blisters</b>            |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Frequent Headaches</b>        |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Gastrointestinal Problems</b> |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Glaucoma</b>                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Heart History</b>             |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Heart Surgery</b>             |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hemophilia</b>                |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| Y  | N                        | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hepatitis A</b>               |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |                          |      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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Hepatitis B</b>               |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>HIV+ AIDS</b>                 |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>High Blood Pressure</b>       |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Kidney Problems</b>           |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Liver Disease</b>             |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Low Blood Pressure</b>        |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Mitral Valve Prolapse</b>     |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Multiple Sclerosis</b>        |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Muscular Dystrophy</b>        |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Pace Maker</b>                |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Pneumocystitis</b>            |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Psychiatric</b>               |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Radiation Therapy</b>         |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Rheumatic Fever</b>           |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Seizures</b>                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Shingles</b>                  |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Sickle Cell Disease</b>       |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Sinus Problems</b>            |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Stroke</b>                    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>TBI</b>                       |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Thyroid Problems</b>          |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Tuberculosis</b>              |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Ulcers</b>                    |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Venereal Disease/STD</b>      |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Yellow Jaundice</b>           |                          |                          |                          |                          |                          |                  |                          |                          |                          |                          |               |                          |                          |                          |                          |                        |                          |                          |                          |                          |                  |                          |                          |                          |                          |                                |                          |                          |                          |                          |                               |                          |         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**CURRENT MEDICATIONS:**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Over The Counter Products:**

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## PATIENT HISTORY

1. Name of last dentist: \_\_\_\_\_

2. Date of last dental visit? \_\_\_\_\_

3. What was the reason patient last visited a dentist? \_\_\_\_\_

4. Was patient ever sedated (asleep) for dental treatment?

\_\_\_\_\_ YES \_\_\_\_\_ NO

5. Is patient presently experiencing discomfort?

\_\_\_\_\_ YES \_\_\_\_\_ NO

If yes please explain. \_\_\_\_\_

6. Does patient brush independently?

\_\_\_\_\_ YES \_\_\_\_\_ NO

How often? \_\_\_\_\_

7. Do patient's gums bleed when teeth are brushed?

\_\_\_\_\_ YES \_\_\_\_\_ NO

8. Does patient have any loose teeth that you know of?

\_\_\_\_\_ YES \_\_\_\_\_ NO

9. Does patient often have unpleasant breath?

\_\_\_\_\_ YES \_\_\_\_\_ NO

10. Does patient have any difficulty chewing?

\_\_\_\_\_ YES \_\_\_\_\_ NO

11. Are any teeth sensitive to hot, cold, sweet? (Please circle all that apply)

\_\_\_\_\_ YES \_\_\_\_\_ NO

12. What kind of food does patient eat?

Choose ALL THAT APPLY:

\_\_\_\_\_ Solid food \_\_\_\_\_ Ground or blenderized food \_\_\_\_\_ Feeding tube of any kind

13. Does patient have difficulty swallowing?

\_\_\_\_\_ YES \_\_\_\_\_ NO

14. Does patient have any difficulty breathing?

\_\_\_\_\_ YES \_\_\_\_\_ NO

15. Does patient tolerate x-rays?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

16. Will patient sit for dental scaling and polishing?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

17. Will patient sit still/tolerate dental exam with exam lights, gloves and hands in mouth?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

18. If patient uses a wheelchair, can patient independently transfer from wheelchair to dentist chair?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

19. Remarks (including aggressive behaviors) on patient tolerance and cooperation.

20. Who will accompany the patient to the dentist office? (Name and phone number)

21. Please list any barriers or obstacles that may interfere with or affect dental treatment.

22. Dental Insurance that pays for some or all dental care:

Medicaid Billing Number \_\_\_\_\_

\_\_\_ Molina \_\_\_ CareSource \_\_\_ Amerigroup \_\_\_ Wellcare \_\_\_ Anthem \_\_\_ Buckeye \_\_\_ Unison \_\_\_ Paramount

\_\_\_ Private insurance

\_\_\_ Patient/Family will pay

23. Where can consumer be found during the day? \_\_\_\_\_

24. How may we assist you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PRINTED NAME \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_